		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038331

Facility Name: HERITAGE MANOR-STREATOR

Address: 1525 E. MAIN STREET (Number) STREATOR (City) 61701 (Zip Code)

County: LASALLE

Telephone Number: (815) 672-4516 **Fax #** ( )

IDPA ID Number: 370909086014

Date of Initial License for Current Owners: 1964

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[xx] PROPRIETARY		[ ] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[xx]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) CRAIG L. ATER
(Title) SENIOR V.P. FINANCE

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Previe

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	28,322	9,234	1,142	38,698	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	28,322	9,234	1,142	38,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.12%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 1965 and days of care provided _____

Medicare Intermediary MUTUAL OF OHMAHA

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	9948	9948	0
IPA	28322	28322	0
medicare	1142	1142	0
	39412	39412	

IPA BEDHOLDS	0
PP BEDHOLDS	694
PP CONVERS	20

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	213,761	20,516		234,277		234,277	2,672	236,949			1
2	Food Purchase		172,947		172,947		172,947	(886)	172,061			2
3	Housekeeping	87,317	21,433		108,750		108,750	0	108,750			3
4	Laundry	39,652	13,938		53,590		53,590	0	53,590			4
5	Heat and Other Utilities			63,366	63,366		63,366	931	64,297			5
6	Maintenance	65,257	25,055	17,001	107,313		107,313	9,456	116,769			6
7	Other (specify):*							0				7
8	TOTAL General Services	405,987	253,889	80,367	740,243		740,243	12,173	752,416			8
	B. Health Care and Programs											
9	Medical Director			0				0				9
10	Nursing and Medical Records	1,201,538	90,484	5,011	1,297,033		1,297,033	0	1,297,033			10
10a	Therapy		113,776	49,438	163,214	(330,295)	(167,081)	212,200	45,119			10a
11	Activities	60,070	(222)	360	60,208		60,208	0	60,208			11
12	Social Services	28,741	44	3,759	32,544		32,544	0	32,544			12
13	Nurse Aide Training	2,472	586		3,058		3,058	2,330	5,388			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,292,821	204,668	58,568	1,556,057	(330,295)	1,225,762	214,530	1,440,292			16
	C. General Administration											
17	Administrative	61,206			61,206		61,206	35,991	97,197			17
18	Directors Fees							2,731	2,731			18
19	Professional Services			306,578	306,578		306,578	(298,319)	8,259			19
20	Dues, Fees, Subscriptions & Promotions			73,559	73,559	(60,390)	13,169	(2,773)	10,396			20
21	Clerical & General Office Expenses	109,087	8,504	8,887	126,478		126,478	133,127	259,605			21
22	Employee Benefits & Payroll Taxes			315,208	315,208		315,208	20,995	336,203			22
23	Inservice Training & Education			1,912	1,912		1,912	87	1,999			23
24	Travel and Seminar			5,549	5,549		5,549	(3,550)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			11,426	11,426		11,426	1,283	12,709			26
27	Other (specify):*			2,754	2,754		2,754	(2,754)				27
28	TOTAL General Administration	170,293	8,504	725,873	904,670	(60,390)	844,280	(113,182)	731,098			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,869,101	467,061	864,808	3,200,970	(390,685)	2,810,285	113,521	2,923,806			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			97,681	97,681		97,681	11,688	109,369			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			120,604	120,604		120,604	(12,499)	108,105			32
33	Real Estate Taxes			44,620	44,620		44,620	0	44,620			33
34	Rent-Facility & Grounds							7,773	7,773			34
35	Rent-Equipment & Vehicles			13,503	13,503		13,503	3,712	17,215			35
36	Other (specify):*							0				36
37	TOTAL Ownership			276,408	276,408		276,408	10,674	287,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					330,295	330,295	0	330,295			39
40	Barber and Beauty Shops	0	830	6,807	7,637		7,637	0	7,637			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					60,390	60,390	0	60,390			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		830	6,807	7,637	390,685	398,322		398,322			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,869,101	467,891	1,148,023	3,485,015	0	3,485,015	124,195	3,609,210			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,789)	35		5
6	Rented Facility Space	(100)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,236	30		9
10	Interest and Other Investment Income	(11,703)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(886)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(908)	23		16
17	Non-Care Related Fees	(692)	20		17
18	Fines and Penalties				18
19	Entertainment	(9,813)	24		19
20	Contributions	(1,475)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(225)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,279)	27		24
25	Fund Raising, Advertising and Promotional	(5,550)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,184)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	164,379		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 164,379		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 124,195		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **HERITAGE MANOR-STREATOR**

IDH **003833**

Report Period Beginning: **1/1/21 00**

Ending: **12/31/00**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
	The information listed in B13 thru G65 is from Page 5.		
1	**Day Care**	0	0
2	**Other Care for Outpatients**	0	0
3	**Governmental Sponsored Special Programs**	0	0
4	**Non-Patient Meals**	0	0
5	**Telephone, TV & Radio in Resident Rooms**	(12,788)	35
6	**Rented Facility Space**	(100)	34
7	**Sale of Supplies to Non-Patients**	0	
8	**Laundry for Non-Patients**	0	
9	**Non-Straight-line Depreciation**	5,236	30
10	**Interest and Other Investment Income**	(11,760)	32
11	**Discounts, Allowances, Rebates & Refunds**	0	
12	**Non-Working Officer's or Owner's Salary**	0	
13	**Sales Tax**	(886)	2
14	**Non-Care Related Interest**	0	32
15	**Non-Care Related Owner's Transactions**	0	
16	**Personal Expenses (Including Transportation)**	(968)	23
17	**Non-Care Related Fees**	(692)	20
18	**Fines and Penalties**	0	
19	**Entertainment**	(9,833)	24
20	**Contributions**	(1,475)	27
21	**Owner or Key Man Insurance**	0	
22	**Special Legal Fees & Legal Retainers**	(225)	19
23	**Malpractice Insurance for Individuals**	0	
24	**Bad Debt**	(1,279)	27
25	**Goodwill Writing, Advertising and Promotional**	(5,750)	20
26	**Income & 11. Personal Property Replacement Taxes**	(2,500)	20
27	**Nurse Aide Training for Non-Employees**	0	0
28	**Yellow Page Advertising**	0	0
29	**Non-Paid Workers**	0	0
30	**Donated Goods**	0	0
31	**Amortization Expense**	0	0
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Sch V Line	Adj. Summary
Line 1	0
Line 2	(886)
Line 3	0
Line 4	0
Line 5	(12,788)
Line 6	(100)
Line 7	0
Line 8	(968)
Line 9	5,236
Line 10	(11,760)
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	(9,833)
Line 19	(1,475)
Line 20	(8,442)
Line 21	0
Line 22	(225)
Line 23	(9,833)
Line 24	(1,475)
Line 25	(8,442)
Line 26	0
Line 27	(13,754)
Line 28	(2,500)
Line 29	(29,913)
Line 30	0
Line 31	0
Line 32	(11,760)
Line 33	0
Line 34	(100)
Line 35	(12,788)
Line 36	0
Line 37	(14,888)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(69,114)

Print Other Adjustment

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	2,672	0	0	0	0	0	0	0	0	2,672	1
2	Food Purchase	(886)	0		0	0	0	0	0	0	0	0	(886)	2
3	Housekeeping	0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	931	0	0	0	0	0	0	0	0	931	5
6	Maintenance	0	0	9,456	0	0	0	0	0	0	0	0	9,456	6
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(886)	0	13,059	0	0	0	0	0	0	0	0	12,173	8
	B. Health Care and Programs													
9	Medical Director	0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(201)		0	212,401	0	0	0	0	0	0	212,200	10a
11	Activities	0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	2,330	0	0	0	0	0	0	0	0	2,330	13
14	Program Transportation	0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(201)	2,330	0	212,401	0	0	0	0	0	0	214,530	16
	C. General Administration													
17	Administrative	0	0	35,991	0	0	0	0	0	0	0	0	35,991	17
18	Directors Fees	0	0	2,731	0	0	0	0	0	0	0	0	2,731	18
19	Professional Services	(225)	0	8,259	0	(306,353)	0	0	0	0	0	0	(298,319)	19
20	Fees, Subscriptions & Promotions	(6,242)	0	3,469	0	0	0	0	0	0	0	0	(2,773)	20
21	Clerical & General Office Expenses	0	0	133,127	0	0	0	0	0	0	0	0	133,127	21
22	Employee Benefits & Payroll Taxes	0	0	20,995	0	0	0	0	0	0	0	0	20,995	22
23	Inservice Training & Education	(908)	0	995	0	0	0	0	0	0	0	0	87	23
24	Travel and Seminar	(9,813)	0	6,263	0	0	0	0	0	0	0	0	(3,550)	24
25	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,283	0	0	0	0	0	0	0	0	1,283	26
27	Other (specify):*	(2,754)	0	0	0	0	0	0	0	0	0	0	(2,754)	27
28	**TOTAL General Administration**	(19,942)	0	213,113	0	(306,353)	0	0	0	0	0	0	(113,182)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,828)	(201)	228,502	0	(93,952)	0	0	0	0	0	0	113,521	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,236	0	0	6,452	0	0	0	0	0	0	0	11,688	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	(11,703)	0	0	(796)	0	0	0	0	0	0	0	(12,499)	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(100)	0	0	7,873	0	0	0	0	0	0	0	7,773	34
35	Rent-Equipment & Vehicles	(12,789)	0	0	16,501	0	0	0	0	0	0	0	3,712	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,356)	0	0	30,030	0	0	0	0	0	0	0	10,674	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,184)	(201)	228,502	30,030	(93,952)	0	0	0	0	0	0	124,195	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0030231 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V		$			$	$	1
2	V	10c Adjustment for Related Organization	65,132	GreenTree Therapy	100.00%	44,931	(20[illegible]	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 65,132			$ 44,931	$ * (20[illegible]	14

Sum_6

-201

* Total must agree with the amount recorded on line 30 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 2,672	$ 2,672	15	2672
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				931	931	19	931
20	V	6	Maintenance				9,456	9,456	20	9456
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				2,330	2,330	26	2330
27	V	14	Program Transportation				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				35,991	35,991	29	35991
30	V	18	Directors Fees				2,731	2,731	30	2731
31	V	19	Professional Services				8,259	8,259	31	8259
32	V	20	Fees, Subscription, Promotions				3,469	3,469	32	3469
33	V	21	Clerical & General Office Expenses				133,127	133,127	33	133127
34	V	22	Employee Benefits & Payroll Taxes				20,995	20,995	34	20995
35	V	23	Inservice Training & Education				995	995	35	995
36	V	24	Travel and Seminar				6,263	6,263	36	6263
37	V	25	Other Admin. Staff Transportation				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				1,283	1,283	38	1283
39	Total			$			$ 228,502	$ * 228,502	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				6,452	6,452	16	6452
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(796)	(796)	18	-796
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				7,873	7,873	20	7873
21	V	35	Rent-Equipment & Vehicles				16,501	16,501	21	16501
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 30,030	$ * 30,030	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	Adjustment for Related Organization	$ 306,353	Heritage Enterprises, Inc.		$	$ (306,353)	15	-306353
16	V								16	
17	V	10a	Adjustment for Related Organization	113,588	Green Tree Pharmacy	100.00%	325,989	212,401	17	212401
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 419,941			$ 325,989	$ * (93,952)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	0.26	18,319	10	0.20	Directors Fee	$ 911	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Treas	Management	0.10	18,320	10	0.20	Directors Fees	910	line 18, col 7	2
3	Craig Hart	Secretary/Treasurer	Management	0.20	18,320	10	0.20	Directors Fees	910	line 18, col 7	3
4	Bill Froelich	Chairman of Board	Management	0.26	130,991	10	0.20	Salary	6,509	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Treas	Management	0.10	130,992	10	0.20	Salary	6,508	line 17, col 7	5
6	Craig Hart	Secretary/Treasurer	Management	0.20	108,477	10	0.20	Salary	5,390	line 17, col 7	6
7	Joe Warner	President	Management	0.03	102,377	48	0.95	Salary	5,086	line 17, col 7	7
8	Bob Dickson	Executive Vice Presid	Management	0.01	66,703	50	1.00	Salary	3,314	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Presid	Management	0.00	54,949	50	1.00	Salary	2,730	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Presid	Management	0.00	54,672	50	1.00	Salary	2,716	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.00	33,750	40	1.00	Salary	1,677	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.00	41,492	50	1.00	Salary	2,061	line 17, col 7	12
13								TOTAL	$ 38,722		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il 61701
Phone Number: (309) 823-7135
Fax Number: (309) 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,324	23	$ 56,457	$ 56,457	110	$ 2,672	1
2	2	Food Purchase	BEDS	2,324	23	6	0	110	0	2
3	3	Housekeeping	BEDS	2,324	23	0	0	110	0	3
4	4	Laundry	BEDS	2,324	23	0	0	110	0	4
5	5	Heat & Other Utilities	BEDS	2,324	23	19,665	0	110	931	5
6	6	Maintenance	BEDS	2,324	23	199,772	50,885	110	9,456	6
7	7	Other	BEDS	2,324	23	0	0	110	0	7
8	9	Medical Director	BEDS	2,324	23	0	0	110	0	8
9	10	Nursing & Medical Records	BEDS	2,324	23	0	0	110	0	9
10	11	Activities	BEDS	2,324	23	0	0	110	0	10
11	12	Social Service	BEDS	2,324	23	0	0	110	0	11
12	13	Nurse Aide Training	BEDS	2,324	23	49,237	43,081	110	2,330	12
13	14	Program Transportation	BEDS	2,324	23	0	0	110	0	13
14	15	Other	BEDS	2,324	23	0	0	110	0	14
15	17	Administrative	BEDS	2,324	23	760,393	760,393	110	35,991	15
16	18	Directors Fees	BEDS	2,324	23	57,693	0	110	2,731	16
17	19	Professional Services	BEDS	2,324	23	174,483	0	110	8,259	17
18	20	Fees, Subscription, Promotions	BEDS	2,324	23	73,288	0	110	3,469	18
19	21	Clerical & General Office Expense	BEDS	2,324	23	2,812,617	2,533,181	110	133,127	19
20	22	Employee Benefits & Payroll Taxe	BEDS	2,324	23	443,562	0	110	20,995	20
21	23	Inservice Training & Education	BEDS	2,324	23	21,017	0	110	995	21
22	24	Travel and Seminar	BEDS	2,324	23	132,330	0	110	6,263	22
23	25	Other Admin. Staff Transportatio	BEDS	2,324	23	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	BEDS	2,324	23	27,096	0	110	1,283	24
25	TOTALS					$ 4,827,616	$ 3,443,997		$ 228,502	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,324	23	$ 0	$ 0	110	$ 0	1
2	30	Depreciation	BEDS	2,324	23	136,322	0	110	6,452	2
3	31	Amortization of Pre-Op & Org	BEDS	2,324	23	0	0	110	0	3
4	32	Interest	BEDS	2,324	23	(16,821)	0	110	(796)	4
5	33	Real Estate Taxes	BEDS	2,324	23	0	0	110	0	5
6	34	Rent-Facility & Grounds	BEDS	2,324	23	166,328	0	110	7,873	6
7	35	Rent-Equipment & Vehicles	BEDS	2,324	23	348,617	0	110	16,501	7
8	36	Other	BEDS	2,324	23	0	0	110	0	8
9	38	Medically Nec Transportation	BEDS	2,324	23	0	0	110	0	9
10	39	Ancillary Service Centers	BEDS	2,324	23	0	0	110	0	10
11	40	Barber and Beauty Shops	BEDS	2,324	23	0	0	110	0	11
12	41	Coffee and Gift Shops	BEDS	2,324	23	0	0	110	0	12
13	42	Other	BEDS	2,324	23	0	0	110	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 634,446	$		$ 30,030	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	National City		XX	Mortage	$10,970.00	01/20/94	$ 1,700,000	$ 1,117,503	01/20/01	0.0725	$ 85,688	1
2	National City Loan Amortization		XX	Mortgage							1,110	2
3	Central Office Allocation		XX	Interest Income							(796)	3
4												4
5												5
	Working Capital											
6												6
7	National City working Capital										33,806	7
8												8
9	TOTAL Facility Related				$10,970.00		$ 1,700,000	$ 1,117,503			$ 119,808	9
	B. Non-Facility Related*											
10	Interest Income										(11,703)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,700,000	$ 1,117,503			$ 108,105	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	48,198	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	45,277	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,921)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	47,541	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	44,620	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	50,411	8
	1996	53,400	9
	1997	58,759	10
	1998	57,580	11
	1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1965	$ 17,000	1
2	Nursing Home				2
3	TOTALS			$ 17,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	56		1964		$ 348,848	$		$	$	$	4
5	54		1967		440,122						5
6											6
7											7
8											8
	Improvement Type**										
9	1980 Improvements			1980	12,172						9
10	1981 Improvements			1981	13,748						10
11	1982 Improvements			1982	18,366						11
12	1983 Improvements			1983	9,250						12
13	1984 Improvements			1984	1,329						13
14	1985 Improvements			1985	4,100						14
15	1986 Improvements			1986	57,336						15
16	1987 Improvements			1987	6,225						16
17	1988 Improvements			1988	48,818						17
18	1989 Improvements			1989	22,687						18
19	1990 Improvements			1990	31,584						19
20	1991 Improvements			1991	3,560						20
21	1992 Improvements			1992	19,172						21
22	1993 Improvements			1993	23,135						22
23	1994 Improvements			1994	22,036						23
24	1995 Improvements			1995	39,228						24
25	YORK CONDENSING UNIT			1996	3,910						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							6,452	6,452		34
35	Book Depreciation					51,254		56,717	5,463	907,913	35
36	TOTAL (lines 4 thru 35)				$ 1125626	$ 51,254		$ 63,169	$ 11,915	$ 907,913	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Interior Rehab---Facility			1997	286,974						9
10	Roof			1997	5,232						10
11	Sprinkler System			1997	9,530						11
12	Code Alert			1997	1,879						12
13											13
14	Code Alert			1998	2,000						14
15	Bathroom Door			1998	656						15
16	Interior Rehab			1998	11,815						16
17											17
18	Door Alarms			1999	3,675						18
19											19
20	Water Heater			2000	4,114						20
21	Exhaust Fans			2000	931						21
22	Booster Heater -- Water Heater			2000	1,465						22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 625,495	$ 46,427	$ 46,200	$ (227)		$ 486,069	37
38	Current Year Purchases	3,468						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 628,963	$ 46,427	$ 46,200	$ (227)		$ 486,069	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 97,681	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 109,369	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 11,688	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,393,982	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Professional Fees--Renovation	$ 16,259	58
59			59
60			60
61		$ 16,259	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 17,215 Description: Copier, Cell Phone and Central Office Allocation
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		586		586
3	Classroom Wages (a)		2,472		2,472
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,330		2,330
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 5,388	$	$ 5,388
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,388			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$	593	$ 15,115	$	593	$ 15,115	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs		145	6,687		145	6,687	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs		973	23,129	188	973	23,317	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				325,989		325,989	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				4,306			4,306	13
14	TOTAL			$	1,711	$ 49,237	$ 326,177	1,711	$ 375,414	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj -2749
st adj 2855
Ot adj -307

drugs 212401

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,912	$	1
2	Cash-Patient Deposits	7,297		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	372,952		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,988		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,141,935		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,566,084	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	1,342,442		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	603,757		16
17	Accumulated Depreciation (book methods)	(858,207)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	0		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,137,992	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,704,076	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,847	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,297		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,361		30
31	Accrued Taxes Payable (excluding real estate taxes)	12		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,541		32
33	Accrued Interest Payable	9,620		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 300,678	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,117,503		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,117,503	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,418,181	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,285,895	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,704,076	$	48

***(See instructions.)**

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,992,220	1
2	Restatements (describe):		2
3	**audit Adjustment**	(59,377)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,932,843	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	353,052	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 353,052	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,285,895	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,833,885	1
2	Discounts and Allowances for all Levels	(332,480)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,501,405	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	73,742	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 73,742	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	0	11
12	Gift and Coffee Shop	1,217	12
13	Barber and Beauty Care	10,585	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	100	16
17	Sale of Drugs	240,778	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,581	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 254,261	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	11,703	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,703	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other	(3,044)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (3,044)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,838,067	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 740,243	31
32	Health Care	1,556,057	32
33	General Administration	904,670	33
	B. Capital Expense		
34	Ownership	276,408	34
	C. Ancillary Expense		
35	Special Cost Centers	7,637	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,485,015	40
41	**Income before Income Taxes (line 30 minus line 40)****	353,052	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 353,052	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,626	2,148	$ 37,661	$ 17.53	1
2	Assistant Director of Nursing	1,975	2,175	40,339	18.55	2
3	Registered Nurses	7,517	8,267	156,356	18.91	3
4	Licensed Practical Nurses	15,038	16,915	253,267	14.97	4
5	Nurse Aides & Orderlies	69,761	75,110	639,380	8.51	5
6	Nurse Aide Trainees	197	197	2,472	12.55	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,835	6,251	74,535	11.92	8
9	Activity Director					9
10	Activity Assistants	7,341	8,127	60,070	7.39	10
11	Social Service Workers	3,349	3,671	28,741	7.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,380	28,425	213,761	7.52	15
16	Dishwashers					16
17	Maintenance Workers	6,358	6,770	65,257	9.64	17
18	Housekeepers	11,439	12,501	87,317	6.98	18
19	Laundry	5,381	6,007	39,652	6.60	19
20	Administrator	2,080	2,080	61,206	29.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,244	10,101	109,087	10.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,521	188,745	$ 1,869,101 *	$ 9.90	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		0		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,156		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,759		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 6,915		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Colson	Administrator	0.00%	$ 61,206
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,206

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 306,353
All Legal is adjusted to zero	Legal	225
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 306,578

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,030
Unemployment Compensation Insurance	19,466
FICA Taxes	142,986
Employee Health Insurance	96,236
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	25,490
Employee Benefits - central office	20,995
TOTAL (agree to Schedule V, line 22, col.8)	$ 336,203

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	873
Health Care Worker Background Check	
(Indicate # of checks performed)	266
Central Office Allocation	3,469
Promotional Advertising	2,361
Public Relations	3,189
Dues and Subscriptions	5,441
License and Fees	839
Less: Public Relations Expense	(3,189)
Non-allowable advertising	(692)
Yellow page advertising	(2,361)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,396

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,004
	30
Seminar Expense	2,515
Non Allowable	(9,813)
Central Office Allocation	6,263
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number HERITAGE MANOR-STREATOR # 0038331 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **yes** If YES, have these costs
been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,000** Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **xx** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **60,390**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **no** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **yes** Indicate the amount. $ **4,246**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned for providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **no** If no, please explain. **Not complete as of the filing date.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount	
1009			PETTY CASH	2912						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	372952						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1135			ACCOUNTS RECEIVABLE-IC							
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	40988						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY							
1310			SUPPLIES INVENTORY							
1409			LAND	50000						
1450			FURNITURE & EQUIPMENT	603757						
1460			ACCUM DEPR-FURN & EQUIP	-451030						
1475			BUILDING & IMPROVEMENTS	1342442						
1490			ACCUM DEPR-BUILDING	-407177						
1530			RESIDENT FUNDS	7297						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	4141935						
2010			ACCOUNTS PAYABLE	-34847						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-87376						
2110			ACCRUED VACATION PAY	-113985						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-12	-12					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	-9620						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE							
2350			REAL ESTATE TAX PAYABLE	-47541						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS							
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-7297						
2600			MORTGAGE PAYABLE	-1117503						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-3932843						
2970			PROFIT/LOSS FOR PERIOD	-353052						
3007.1			PATIENT DAYS-PRIVATE	9948						
3007.2			PATIENT DAYS-IPA	28322						
3007.3			PATIENT DAYS-MEDICARE	1142						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-1053185		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	-2271055		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	-256038		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE	-47558		0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVATE	-206049		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	-240778		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-73742		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT INC							
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	332480		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16	RENT INCOME	-100		6	0	6	-100	
3530		13	BEAUTY SHOP	-10585		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	-307		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	-910		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	0		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	-1581		0	0	0	0	
3600		21	MISC INCOME	0		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	100710	109087	21	1	17	0	
4111			ADMINISTRATOR WAGES	61206	61206	17	1	0	0	
4115			VACATION & SICK - G&A	8377		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	13103	315208	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0	
4130			EMPLOYEE SCHOLORSHIP WAGE	8161		21	1	0	0	
4135			EMPLOYEE SCHOLORSHIP COST	4226		23	3	0	0	
4220			DIRECTORS FEES			18	3	0	0	
4250	4255		OFFICE SUPPLIES	8504	8504	21	2	0	0	
4260			TELEPHONE	8887	8887	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	1912	1912	23	3	16	-908	
4280			GENERAL TRAVEL	3004	5549	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	30		24	3	19	0	
4285			EDUCATION & SEMINAR	2515		24	3	19	-9813 ***	
4290			HELP WANTED ADVERTISING	873	73559	20	3	0	0	-60390
4291			PROMOTIONAL ADVERTISING	2361		20	3	25	-2361	
4292			PUBLIC RELATIONS	3189		20	3	25	-3189	
4300			LICENSES & FEES	61429		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	5441		20	3	17	-692	
4320			CONTRIBUTIONS	1475		27	3	20	-1475	
4350			PROFESSIONAL FEES	225	306578	19	3	22	-225	
4355			MEDICAL DIRECTOR	0	0	9	3	0	0	
4360			UTILIZATION REVIEW			10	3	0	0	
4361			OTHER PHYSICIAN FEES	0		39	3	0	0	
4362			MEDICAL RECORDS CONSULT	0		10	3	0	0	
4363			PHARMACIST FEES	3156		10	3	0	0	
4364			SOC SERV/ACT CONSULT	3759	3759	12	3	0	0	
4370			TV RENTAL	12789		35	3	5	-12789	
4380			INCOME TAXES		2754	27	3	26	0	
4383			BACKGROUND CHECKS	266		20	3	26	0	
4400			PAYROLL TAXES	156973		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	5479		22	3	0	0	
4410			GROUP INSURANCE	96236		22	3	0	0	
4420			LIABILITY INSURANCE	11426	11426	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANCE	31030		22	3	0	0	
4450			CENTRAL OFFICE FEES	306353		19	3	34	-306353	
4460			BAD DEBTS	1279		27	3	24	-1279	
4470			LOST ITEMS-RESIDENTS	0		27	3	0		
4490			MISCELLANEOUS			27	3	0	0	
4510			REAL ESTATE TAXES	44620	44620	33	3	0	0	
4600			LEASED EQUIPMENT	714	13503	35	3	16	0	
5110			MAINTENANCE SALARIES	60866	65257	6	1	0	0	
5120			MAINTENANCE SICK & VAC	4391		6	1	0	0	
5130			ELECTRIC	29503	63366	5	3	0	0	
5131			NATURAL GAS	23755		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	10108		5	3	0	0	
5134			TRASH COLLECTION	5068	17001	6	3	0	0	
5140			PROPERTY PLANT REPLACEMNT	5491	25055	6	2	0	0	
5160			GENERAL REPAIR & MAINT	19564		6	2	0	0	
5165			MAINTENANCE CONTRACTS	11933		6	3	0	0	
5210			DIETARY WAGES	198388	213761	1	1	0	0	
5220			DIETARY SICK & VAC	15373		1	1	0	0	
5240			SALES TAX			2	3	13	-886	
5248			FOOD PURCHASES	177193	172947	2	2	0	0	
5250			SUPPLIES-DISHWASHING	3738	20516	1	2	0	0	
5260			DIETARY REPLACEMENT	2730		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	14048		1	2	0	0	
5295			MEAL CREDIT	-4246		2	2	0	0	
5310			LAUNDRY WAGES	36491	39652	4	1	0	0	
5340			LAUNDRY SICK & VAC	3161		4	1	0	0	
5370			LAUNDRY REPLACEMENT	6909	13938	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	7029		4	2	0	0	
5410			HOUSEKEEPING WAGES	79902	87317	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	7415		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	0	21433	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PPR	21433		3	2	0	0	
6010			RN WAGES-MEDICARE		1201538	10	1	0	0	
6020			RN WAGES-NON MEDICARE	127418		10	1	0	0	
6030			DON WAGES	37661		10	1	0	0	
6035			ADON	40339		10	1	0	0	
6040			RN SICK & VACATION	28938		10	1	0	0	
6110			LPN WAGES-MEDICARE			10	1	0	0	
6120			LPN WAGES-NON MEDICARE	224021		10	1	0	0	
6130			LPN WAGES OTHER			10	1	0	0	
6140			LPN SICK & VACATION	29246		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	598095		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	41285		10	1	0	0	
6245			CONTRACT NURSES-RN			10	3	0	0	
6246			CONTRACT NURSES-LPN			10	3	0	0	
6247			CONTRACT NURSES-AIDES			10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	2472	2472	13	1	0	0	
6255			NURSE AID TRAINING EXP	586	586	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270			REHAB WAGES	71364		10	1	0	0	
6275			REHAB SICK & VAC	3171		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	78411	90484	10	2	0	0	
6295			NURSING SUPPLIES	10780		10	2	0	0	
6390			REPLACEMENT-NURSING	1293		10	2	0	0	
6490			NURSING OTHER	1855	5011	10	3	0	0	
7280			DRUG PURCHASES	36144	113776	39	2	0	212401 ***	
7281			DRUG PURCHASES-OTHER	77444		39	2			
7380			LABORATORY SERVICES	4306	49438	39	3	0	0	
7410			HOME HEALTH SALARY			39	1	0	0	
7440			HOME HEALTH SICK & VAC			39	1	0	0	
7450			HOME HEALTH EXPENSES			39	3	0	0	
7510			ACTIVITES WAGES	53718	60070	11	1	0	0	
7540			ACTIVITIES SICK & VAC	6352		11	1	0	0	
7590			ACTIVITIES SUPPLIES	-222	-222	11	2	0	0	
7595			ACTIVITIES FEES	360	360	11	3	0	0	
7610			PT WAGES			39	1	0	0	
7611			PT SICK & VACATION			39	1	0	0	
7620			PT FEES	25878		39	3	0	-2749 ***	
7660			PT SUPPLIES	188		39	2	0	0	
7710			SOCIAL SERVICE WAGES	15525	28741	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	523		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	44	44	12	2	0	0	
7740			OT FEE	15422		39	3	0	-307 ***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	3832		39	3	0	2855 ***	
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	6807	6807	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	830	830	40	2	0	0	
7910			VOLUNTEER COORDINATOR	12187		21	1	0	0	
7940			VOL COORD SICK & VAC	506		21	1	0	0	
7960			VOL COORD SUPPLIES	0		21	2	0	0	
8100			RENT		0	34	3	0	0	
8120			INTEREST EXPENSE	119494	120604	32	3	14	0	
8130			DEPRECIATION	97681	97681	30	3	9	5236	
8150			LOAN FEE AMORTIZATION	1110		32	3	0	0	60390
9510			INTEREST INCOME	-11703		32	0	10	-11703	
9520			MISC NON-OPERATING INCOME	3145		0	0	0	0	
9700			INCOME TAXES	-101		0	0	0	0	
				3476356	3485015					
					8659					
GRAND TOTALS				-353052					-134337	
				(NET INCOME)						
				0						
			FACILITY NAME:							
			FACILITY ID:	0						
			FACILITY UNITS:	89						
			BALANCE SHEET TOTAL	0						
				353052						

1009	1009 PETTY CAS	2912
1100	1100 ACCTS REC	44,947
1101	1101 ALLOWAN	(11,000)
1105		
1110	1110 ACCTS REC	50,415
1125	1125 ACCTS REC	275,357
1130	1130 M/C COST I	0
1135	1135 ACCTS REC	13,233
1140	1140 UNAPPLIEI	0
1145	1145 A/R SUSPEI	0
1200	1200 PREPAID IN	0
1220	1220 OTHER PRI	13,805
1300	1300 DIETARY I	8,226
1310	1310 SUPPLIES I	7,000
1320	1320 LINEN INV	11,957
1409	1409 LAND	50,000
1450	1450 FURNITUR	603,757
1460		(451,030)
1475		1,342,442
1490	1490 ACCUM DE	(407,177)
1530	1530 RESIDENT	7,297
1550	1550 LOAN FEES	0
1551	1551 LOAN FEES	0
1575	1575 CLOSED	0
1850	1850 INTERCOM	4,141,935
2010	2010 ACCOUNTS	(34,847)
2095	2095 BONUSES I	0
2100	2100 ACCRUED	0
2100	2100 PR CLEARI	(5,226)
2100	2100 PR CLEARI	(75,015)
2100	2100 PR CLEARI	(7,135)
2110	2110 ACCRUED	(113,985)
2120	2120 U.C. TAXES	(1,539)
2125	2125 FICA TAXE	(20)
2130	2130 FEDERAL V	(10)
2140	2140 STATE W/H	(4)
2145	2145 EARNED IN	0
2152	2152 WORKERS	1,750
2225	2225 EMPLOYEE	0
2230	2230 PAYROLL S	0
2235		
2240		
2246		
2250		
2260	2260 WAGE GAR	(189)
2300	2300 ACCRUED	(9,620)
2320	2320 IPA PAYME	0
2350	2350 REAL ESTA	(47,541)
2385		
2391		
2393		
2395		
2400	2400 CURRENT I	(37,731)
2512	2512 DUE TO RE	(7,297)
2600	2600 LASALLE E	(1,117,503)
2600	2600 LOAN ADD	0
2625		
2625		
2695	2695 CURRENT I	37,731
2720	2720 RETAINED	(3,932,843)
	2720 RETAINED	(353,052)
		0

3007	3007 PATIENT D	9,948	
3007	3007 PATIENT D	28,322	
3007	3007 PATIENT D	1,142	
3007	3007 PATIENT DAYS-CONVERSION		
3007	3007 PATIENT DAYS-LICENSED		
3007	3007 PATIENT DAYS-TOTAL		
3007	3007 PATIENT DAYS-CONTRA ACCOUNT		
3010	3010 BASIC CHA	(1,053,185)	
3015	3015 ASSESSME	0	
3020	3020 BASIC CHA	(2,271,055)	
3030	3030 BASIC CHA	(256,038)	
3035	3035 DAY CARE	0	
3040	3040 LIGHT NUF	(16,128)	
3050	3050 MEDIUM N	(12,068)	
3060	3060 HEAVY NU	(16,692)	
3061	3061 SKILLED N	(2,670)	
3080	3080 NURSING S	(21,363)	
3081	3081 NURSING S	(117,090)	
3082	3082 NURSING S	(5,992)	
3083	3083 NURSING S	(61,604)	
3100	3100 DRUGS-ME	(73,293)	
3101	3101 DRUGS-OT	(167,485)	
3110	3110 PHYSICAL	0	
3111	3111 PHYSICAL	(2,442)	
3112	3112 PHYSICAL	(32,840)	
3113	3113 PHYSICAL	(6,011)	
3130	3130 PUBLIC AII	0	
3140	3140 LABORATC	(2,427)	
3150	3150 ST/OT THE	0	
3151	3151 ST/OT THE	(2,336)	
3152	3152 ST/OT THE	(17,160)	
3153	3153 ST/OT THE	(10,336)	
3160	3160 X-RAY SER	(190)	
3410	3410 IPA/OTHER	194,368	
3411	3411 MEDICARE	12,584	
3415	3415 PRIOR PER	0	
3420	3420 MEDICARE	125,528	
3440	3440 IPA ASSES	0	
3450	3450 MEDICARE	0	
3460	3460 Y/E A/R AD	0	
3500	3520 RENT INCC	0	
3520	3525 CONTRIBU	(100)	
3530	3530 BEAUTY SI	(10,585)	
3560	3560 ACTIVITY I	(307)	
3570	3570 VENDING I	-1140	
3580	3580 PERSONAL	230	
3590	3590 EQUIPMEN	0	
3595	3595 RESIDENT	(1,581)	
3600	3600 MISC INCO	0	-3829408
4110	4110 G&A WAGI	100,710	
4111	4111 ADMINISTI	61,206	
4115	4115 G&A PTO &	8,377	
4120	4120 EMPLOYEE	12,827	
4125	4125 EMPLOYEE	0	
4130	4130 EMPLOYEE	8,161	
4135	4135 EMPLOYEE	4,226	
4245			
4250	4250 OFFICE SUI	4,862	
4255	4255 POSTAGE	2,622	
4260	4260 TELEPHON	8,887	
4275	4275 TRAINING	1,912	
4276	4276 INJURY PR	1,000	
4280	4280 GENERAL T	3,004	
4281	4281 MEAL EXP	30	
4285	4285 EDUCATIO	2,515	
4289			
4290	4290 HELP WAN	873	
4291	4291 PROMOTIO	2,361	
4292	4292 PUBLIC RE	3,189	
4300	4300 LICENSE &	61,429	
4310	4310 DUES & SU	5,441	
4320	4320 CONTRIBU	1,475	
4350	4350 PROFESSIC	225	
4355	4355 MEDICAL I	0	
4360	4360 UTILIZATI	0	
4361	4361 OTHER PH'	0	
4362			
4363	4363 PHARMACI	3,156	
4364	4364 SOCIAL SE	3,759	
4370	4370 TV RENTAI	12,789	
4383	4383 BACKGROI	266	
4390			
4400	4400 PAYROLL T	156,973	
4401	4401 PAYROLL T	5,479	
4410	4410 GROUP INS	96,236	
4420	4420 LIABILITY	11,426	
4430	4430 WORKMAN	28,387	
4435	4435 W/C-FIRST	919	
4436	4436 DRUG TEST	724	
4440			
4450	4450 CENTRAL (	306,353	
4460	4460 BAD DEBT	(2,600)	
4461	4461 BAD DEBT	3,879	
4470	4470 LOST ITEM	0	
4475	4475 UNIFORM I	276	
4486	4486 SERVICE C	5,791	
4490	4490 MISC EXPE	(1,219)	
4496	4496 MISC. M.I.S	1,020	928946
4510	4510 REAL ESTA	44,620	
4600	4600 LEASED EQ	714	
5110	5110 MAINTENA	60,866	
5120	5120 MAINTENA	4,391	
5130	5130 ELECTRIC	29,503	
5131	5131 NATURAL	23,755	
5133	5133 WATER & S	10,108	
5134	5134 TRASH COI	5,068	
5140	5140 PROP/PLAN	5,491	
5160	5160 GENERAL I	19,564	
5165	5165 MAINTENA	6,142	
5166	5166 MAINT.CO	0	
5210	5210 DIETARY W	198,388	
5220	5220 DIETARY P	15,373	
5240	5240 CLOSED AC	0	
5245	5245 TEMPS/COI	0	
5248	5248 FOOD PURC	178,412	
5250	5250 SUPPLIES I	3,738	
5260	5260 REPLACEM	2,730	
5270	5270 KITCHEN S	14,048	
5295	5295 MEAL INC(	(4,246)	
5310	5310 LAUNDRY	36,491	
5340	5340 LAUNDRY	3,161	
5370	5370 REPLACEM	6,909	
5380	5380 OUTSIDE L	305	
5390	5390 SUPPLIES	6,724	
5410	5410 HOUSEKEE	79,902	
5440	5440 HOUSEKEE	7,415	
5480	5480 SUPPLIES-(	0	
5490	5490 SUPPLIES-I	21,433	
6010	6010 RN WAGES	0	
6020	6020 RN WAGES	127,418	
6030	6030 DON WAGI	37,661	
6035	6035 ADON WAC	40,339	
6040	6040 RN PTO & I	28,938	
6110	6110 LPN WAGE	0	
6120	6120 LPN WAGE	224,021	
6130	6130 LPN WAGE	0	
6140	6140 LPN PTO &	29,246	
6210	6210 AIDES WAC	0	
6220	6220 AIDES WAC	598,095	
6230	6230 WARD CLE	0	
6240	6240 AIDES PTO	41,285	
6245	6245 CONTRACT	0	
6246	6246 CONTRACT	0	
6247			
6250	6250 NURSE AID	2,472	
6255	6255 NURSE AID	586	
6260	6260 NURSE AID	0	
6270	6270 REHAB WA	71,364	
6275	6275 REHAB PT(	3,171	
6280	6280 NURSING I	0	
6290	6290 NURSING S	78,411	
6295	6295 NURSING S	10,780	
6390	6390 REPLACEM	1,293	
6490	6490 OTHER	1,855	
7280	7280 DRUG PUR	36,144	
7281	7281 DRUG PUR	77,444	
7380	7380 LABORATC	3,973	
7391	7391 AMBULAN	333	
7393	7450 HOME HEA	0	
7510	7510 ACTIVITIE	53,718	
7540	7540 ACTIVITIE	6,352	
7590	7590 ACTIVITIE	(222)	
7595	7595 ACTIVITIE	360	
7610	7610 PHYSICAL	0	
7611	7611 PHYSICAL	0	
7620	7620 PHYSICAL	25,878	
7660	7660 P.T. SUPPL'	188	
7710	7710 SOCIAL SE	15,525	
7720	7720 SOCIAL SE	523	
7730	7730 SOCIAL SE	44	
7740	7740 OCCUPATI	15,422	
7750	7750 SOCIAL TH	0	
7770	7770 SPEECH TH	3,832	
7820	7820 BEAUTICIA	6,807	
7890	7890 BEAUTY SI	830	
7910	7910 VOLUNTEE	12,187	
7940	7940 VOLUNTEE	506	
7960	7960 VOLUNTEE	0	
8120	8120 INTEREST	85,688	
8125	8125 ALLOCATE	33,806	
8130	8130 DEPRECIA'	97,681	
8150	8150 LOAN FEE	1,110	
9510	9510 INTEREST I	(11,703)	
9520	9530 GAIN ON S	0	
9530	9533 BOOK VAL	3,145	
9700	9700 EXTRAORI	-101	
		-353052	